

The law on managing patients who deliberately harm themselves and refuse treatment

Barbara Hewson

A recent BMJ paper on managing patients who harm themselves and refuse treatment produced many responses on our website questioning the legality of the advice. Some of these letters are published on p 916. We commissioned Barbara Hewson, a barrister with a specialist interest in the subject, to clarify these issues.

Managing patients with deliberate self harm who refuse treatment in the accident and emergency department is a complex issue. Hassan et al devised one such hypothetical case, found that doctors were not clear about how to approach it, and proposed an algorithm of their own to guide management.¹ As the subsequent correspondence to the *BMJ*'s website shows, some readers are unconvinced by the algorithm. Broadly, I think it provides a helpful summary.

Professors Ian Kennedy and Andrew Grubb, who edit a recent textbook on medical law, say that "Interventions (including medical treatment) may be justified at common law to the extent that it is reasonable to do so in the circumstances, and providing what is done is reasonable, where the competence of the individual is unknown. The common law justification of 'necessity' would come to the aid of the doctor ... an apparent suicide victim may be treated to save her life unless it is absolutely clear that the patient was both attempting to kill herself and was competent at the time to make that decision."² This approach may provide some comfort for doctors who prefer to "treat now, dispute later." However, it does not encompass the problem posed by an adult patient who is alert, conscious and refusing life saving treatment for deliberate self harm. Such a person is presumed competent to refuse, in the absence of evidence to rebut the presumption. When a patient who is not obviously incapacitated (for example, not unconscious) is refusing treatment, even in an emergency, the presumption of competence should apply, unless and until it can be rebutted.

Methods

I considered some recent legal rulings on consent (space prevented a review of all recent court decisions, but some recent ones are referenced below). I also considered Kennedy and Grubb's textbook,² two Law Commission consultation papers,^{3,4} and its final report to parliament on mental incapacity.⁵

The case

In the hypothetical case proposed by Hassan et al, the patient has harmed herself deliberately and is

Summary points

Adults are presumed competent to refuse medical advice and treatment

The burden of rebutting the presumption lies on those wishing to treat a non-compliant patient

A person may remain competent even if detained under the Mental Health Act 1983

A non-compliant person detained for treatment on the grounds of incapacity has the right to a speedy court review of his or her detention

If a patient is genuinely incapacitated, seeking consent is futile

convinced by a friend to attend an accident and emergency department, but refuses treatment once she gets there. As an adult, she is presumed competent to refuse investigation and treatment for her alleged drug overdose of paracetamol and amitriptyline. Prima facie, she is entitled to decline immediate gastric lavage and charcoal therapy, even if her situation constitutes an emergency. Her presence in the accident and emergency department is inconsistent with her professed desire to avoid treatment; but it does not necessarily follow from this that she is either mad or incompetent. There are various theoretical possibilities: (a) she has taken an overdose and is determined to die; (b) she has taken an overdose but would really prefer to live; (c) she does not know what she really wants; (d) she is a liar and has not taken an overdose.

If she were genuinely trying to commit suicide, I would not expect to see her presenting to an accident and emergency department (unless she has changed, or is changing, her mind). The last three possibilities therefore seem most likely. A history should be taken (it is important to know if she has, or has had, any mental illness). Her mental capacity—her capacity to decline investigation and treatment—must be assessed as a priority. In this case, we can eliminate other

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possible factors indicating temporary incapacity, such as head injury, shock, pain, alcohol, or undue influence by a third party. Whether the drugs she has taken could impede capacity should urgently be considered. If possible, she should be assessed by a senior doctor.

The MB test for capacity

The Court of Appeal recently reformulated the test for capacity (in a 1997 "needle phobia" case, *Re MB*).⁶ Using the court's terminology, it is as follows: the patient lacks capacity only if some impairment or disturbance of mental functioning renders her unable to decide whether to consent to or refuse treatment. Inability to make such a decision will occur when (a) she is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question; (b) she is unable to use the information and weigh it up as part of the process of arriving at the decision. If she lacks capacity, as the Court of Appeal pointed out (in the case of *S* in 1998), seeking consent is futile.⁷

The key question is whether she has some impairment or disturbance of mental functioning that prevents her from deciding for herself. This will involve careful questioning of the patient, to ascertain whether she falls at one of the two hurdles outlined above. Ideally, a psychiatrist should be called to review the question of capacity, rather than to consider detention under the Mental Health Act 1983. Detention under the Mental Health Act 1983 does not of itself rebut the presumption of capacity. Moreover, in this particular case there is insufficient time or opportunity to put the complex machinery of detention in motion. Thus it is better to concentrate on the issue of capacity. (If a psychiatrist is not available, then doctors in accident and emergency will just have to do their best).

If her capacity seems intact, the woman should be asked for an unequivocal assurance (to be recorded in writing) that her refusal is an informed decision: that she understands the nature of, and reasons for, the proposed interventions, and the risks and likely

prognosis involved in her decision to refuse it. If she is unwilling to sign a written indication of her refusal, that should also be noted in writing. (This is not the same as, or to be confused with, a disclaimer, which purports to exempt the hospital from liability.)⁷

Can she be detained?

She can be detained only on one of two grounds: if she lacks capacity at common law, under the common law doctrine of necessity,⁸ or if she qualifies for detention under the Mental Health Act 1983.

The Mental Health Act 1983 may not be used to detain a person against their will "merely because [their] thinking process is unusual, even apparently bizarre and irrational, and contrary to the views of the overwhelming majority of the community at large."⁷ Further, the statutory safeguards imposed by the act (such as the requirement in section 11(1) that an application for admission must be made by the nearest relative or an approved social worker) will probably make statutory detention impracticable in the short term.

If the woman were detained for assessment or treatment under the Mental Health Act 1983, medical treatment for her mental disorder may be given without her consent under section 63 of the act, provided it was given by or under the direction of the responsible medical officer. Section 145(1) defines "medical treatment" as including "nursing, and also ... care, habilitation and rehabilitation under medical supervision." A range of acts ancillary to the core treatment for mental disorder fall within the definition, including treating the consequences of a suicide attempt that results from that disorder.⁹

Applying common law

The House of Lords has ruled that a doctor should give a competent patient adequate information to enable the patient to reach a balanced judgment if the patient chooses to do so. It has also upheld the competent patient's right to reject medical advice for reasons which are rational, or irrational, or for no reason.¹⁰ Such a patient could sue for battery and false imprisonment if treated against her will. The problem is how to distinguish a patient who entirely lacks capacity from a competent, albeit irrational, patient.

In 1992 the Court of Appeal offered the following guidance to doctors: "Doctors faced with a refusal of consent have to give very careful and detailed consideration to the patient's capacity to decide at the time when the decision was made. It may not be the simple case of the patient having no capacity because, for example, at that time he had hallucinations. It may be the more difficult case of a temporarily reduced capacity at the time when his decision was made. What matters is that the doctors should consider whether at that time he had a capacity which was commensurate with the gravity of the decision which he purported to make. The more serious the decision, the greater the capacity required."¹¹

It is obvious that a decision to commit suicide is immensely serious. This must be borne in mind when applying the test formulated in the *MB* case. If the patient holds her own on the *MB* test, she should be advised that she is free to go, and free to change her



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mind. If she leaves, the police cannot be called to return her. What if she stays? She may be changing her mind, or trying to; if so, she should be given every encouragement. But if she stays, and remains opposed to treatment, this could suggest that she is suffering from some impairment or disturbance of mental functioning which renders her incompetent.

If she falls at one of the MB hurdles, she can be treated without her consent. Compulsory treatment entails detention (even for a short period). Every detainee has the right to a speedy court review of her detention; but in practice the patient may not be so well informed as to invoke the immediate assistance of lawyers. If she left before she was treated, I doubt that the hospital is obliged to hunt her down (in my view, leaving is a sign of rationality). I also doubt that the police have power to arrest someone in those circumstances.

What if the patient is treated, and then starts an action for battery? The burden of showing that she lacked capacity would lie on the hospital, if it ran a defence of necessity. Evidence might be adduced as to the prevalence of suicidal tendencies among people whose balance of mind is temporarily disturbed. It might be more effective to argue that she changed her mind, or that her continued presence in casualty was a "cry for help" (implied request for treatment) which could not be ignored.

If she is competent, and her refusal is respected, there is no prospect of her later suing (or her estate suing if she dies) for negligence or negligent advice later on. I assume, of course, that she was given the information she needed to understand the potentially lethal consequences of her overdose and the importance of immediate treatment. It is true that failing to treat an incompetent patient could result in a subsequent claim of negligent failure to treat (though if the patient dies, the risk is more theoretical than real). Also more theoretical than real, in my view, is the prospect of a patient claiming that she was negligently treated as competent when she was incompetent (though this underlines the importance for doctors of considering capacity and not ignoring the issue). It is vital to document these cases carefully so that, if a dispute arises, the basis for the advice given and the action taken are fully recorded.

Human rights

Does the Human Rights Act 1998 have an impact on this debate? The act incorporates the European Convention on Human Rights, with full effect from October 2000. Patients' autonomy is protected by article 5(1) of the European Convention on Human Rights. This provides that no one is to be detained save in certain specified cases, in accordance with a procedure prescribed by law. Category (e) concerns the lawful detention of persons of "unsound mind." Article 5(4) guarantees the right to a speedy court review of a person's detention.

Article 5(1)(e) does not refer to incapacity. But it is arguable that incapacity must, to warrant detention for compulsory treatment by a public hospital, equate to "unsound mind." In *Winterwerp v The Netherlands*,¹² a case about a mental patient, the European Court of Human Rights emphasised that article 5(1)(e) obviously did not permit the detention of a person

because his views or behaviour deviate from the norms prevailing in a particular society. It said: "Except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of 'unsound mind.' The very nature of what has to be established before the competent national authority—that is, a true mental disorder—calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement."¹²

Conclusion

The law in this area is complex. Adults are presumed competent to refuse treatment, even in an emergency; but it is not easy to judge in practice what factors are capable of rebutting the presumption. Every case turns on its own facts. The detention of incompetent patients for treatment under a common law power of necessity is controversial, and likely to generate litigation under the Human Rights Act 1998.

Competing interests: None declared.

- 1 Hassan TB, MacNamara AF, Davy A, Bing A, Bodiwala GG. Managing patients with deliberate self harm who refuse treatment in the accident and emergency department. *BMJ* 1999;319:107-9. (Correspondence at www.bmj.com/cgi/content/full/319/7202/107.)
- 2 Kennedy I, Grubb A. *Principles of medical law*. Oxford: Oxford University Press, 1998:117-8.
- 3 Law Commission. *Mentally incapacitated adults and decision making: medical treatment and research*. London: HMSO, 1993. (Consultation paper No 128.)
- 4 Law Commission. *Mentally incapacitated adults and decision making: a new jurisdiction*. London: HMSO, 1993. (Consultation paper No 129.)
- 5 Law Commission. *Mental incapacity*. London: HMSO, 1995.
- 6 Re MB [1997] 2 FLR 541.
- 7 St George's Healthcare NHS Trust v S [1998] 3 All ER 673.
- 8 R v Bournewood Community and Mental Health NHS Trust ex p L [1998] 3 All ER 289.
- 9 B v Croydon HA [1995] Fam 133.
- 10 Sidaway [1985] AC 871, HL, 904-5.
- 11 Re T [1993] Fam 95.
- 12 *Winterwerp v Netherlands* 2 EHRR 387. (Accepted 16 August 1999)

Endpiece

The gifts needed to be prime minister

If one were asked in these days what gift should a prime minister ask first from the fairies, one would name the power of attracting personal friends. Eloquence, if it be too easy, may become almost a curse. Patriotism is suspected, and sometimes sinks almost to pedantry. A Jove-born intellect is hardly wanted, and clashes with the inferiorities. Industry is exacting. Honesty is impractical. Truth is easily offended. Dignity will not bend. But the man who can be all things to all men, who has ever a kind word to speak, a pleasant joke to crack, who can forgive all sins, who is ever prepared for friend or foe but never bitter to the latter, who forgets not men's names, and who is always ready with little words, he is the man who will be supported at a crisis such as one as this that was now in the course of passing. It is for him that men will struggle, and talk, and, if needs be, fight, as though the very existence of the country depended on his political security.

Anthony Trollope, *The Prime Minister*